Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

MEDICATION PRIOR AUTHORIZATION REQUEST FORM
FAX this completed form to 1-888-865-6531
OR Mail request to: Pharmacy Services Prior Authorization Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720

Reset Form | Print Form

Call 1-833-705-1351 to request a 72-hour supply of medication. Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

Increlex®

Note: Form must be completed in full; An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

Prescriber Fax Number - -

☐ **Initiation of Therapy** – complete form and submit all relevant supporting documentation.

-OR-

☐ **Continuation of Therapy** – complete form and submit supporting documentation which should include a **growth chart** demonstrating progression of growth greater than or equal to 2 cm total in one year and final adult height has not been reached.

Diagnoses: (Please check all that apply and submit supporting lab work and documentation.)

☐ **Increlex®** for patient with severe primary insulin-like growth factor (IGF)-1 deficiency (IGFD) defined by:

- Height standard deviation score ≤ -3; **AND**
- Basal IGF-1 standard deviation score ≤ -3; **AND**
- Normal or elevated growth hormone level (greater than 10ng/ml on standard GH stimulation tests) **OR**

☐ **Increlex®** for patient with growth hormone gene deletion who has developed neutralizing antibodies to growth hormone. **(Must submit supporting documentation.)**

Complete Assessment:

1. Is the patient a child older than two years of age with open epiphyses? ☐ Yes ☐ No
2. Is the patient receiving ongoing care from an endocrinologist? Is the current prescriber an endocrinologist? ☐ Yes ☐ No
3. Does the patient have growth failure related to growth hormone deficiency, malnutrition, hypothyroidism, or chronic anti-inflammatory steroid use? *(Thyroid and nutritional deficiencies should be corrected before initiation of Increlex®)* ☐ Yes ☐ No
4. Does the patient have active or suspect neoplasia? ☐ Yes ☐ No

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

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